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Adherence to humanized care practices for newborns with good vitality in the delivery room

Adesão às práticas assistenciais humanizadas ao recém-nascido com boa vitalidade na sala de parto

Adherencia a las prácticas de atención humanizada para recién nacidos con buena vitalidad en la sala de partos

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ABSTRACT

Objective: To know the intervening factors in the adherence of health professionals to humanized care practices for newborns with good vitality in the delivery room.

Method: Qualitative research, through an online form with 36 health professionals working in delivery rooms in Rio de Janeiro. Data processed in the *Interface de R pour Analyses Multidimensionnelles de Textes Et de Questionnaires* and analyzed according to Thematic Content Analysis.

Results: Skin-to-skin contact was identified as a factor that is directly related to timely clamping of the umbilical cord and breastfeeding in the first hour of life. Other intervening factors were: acceptance, training and professional category; type of delivery; qualification and training of teams.

Conclusions: Professional improvement combined with encouragement from the leadership, partnership between peers, good working conditions, human resources and infrastructure and guidance to families provide adherence to humanized care practices for the newborn in the delivery room.

Keywords: Infant, newborn. Humanized delivery. Perinatal care. Delivery rooms.

RESUMO

Objetivo: Conhecer os fatores intervenientes à adesão dos profissionais de saúde às práticas assistenciais humanizadas ao recém-nascido com boa vitalidade na sala de parto.

Método: Pesquisa qualitativa, mediante formulário online com 36 profissionais de saúde atuantes em salas de parto no estado do Rio de Janeiro. Dados processados no *Interface de R pour Analyses Multidimensionnelles de Textes Et de Questionnaires* e analisados segundo Análise de Conteúdo Temática.

Resultados: Identificou-se o contato pele a pele como fator que se relaciona diretamente à realização do clampeamento oportuno do cordão umbilical e amamentação na primeira hora de vida. Outros fatores intervenientes foram: aceitação, formação e categoria profissional; tipo de parto; capacitação e treinamento das equipes.

Conclusões: Aprimoramento profissional aliado ao estímulo da chefia, parceria entre pares, boas condições de trabalho, de recursos humanos e de infraestrutura e orientações às famílias propiciam a adesão às práticas assistenciais humanizadas ao recém-nascido na sala de parto.

Palavras-chave: Recém-nascido. Parto humanizado. Assistência perinatal. Sala de parto.

RESUMEN

Objetivo: Conocer factores involucrados en la adhesión de los profesionales de la salud a las prácticas de atención humanizada al recién nacido con buena vitalidad en la sala de partos.

Método: Investigación cualitativa, utilizando un formulario en línea con 36 profesionales de la salud que trabajan en salas de parto en el estado de Río de Janeiro. Datos procesados mediante la *Interface de R pour Analyses Multidimensionnelles de Textes Et de Questionnaires* y analizados mediante *Thematic Content Analysis*.

Resultados: El contacto piel con piel se identificó como un factor que está directamente relacionado con la realización del pinzamiento oportuno del cordón umbilical y la lactancia materna en la primera hora de vida. Otros factores fueron: aceptación, formación y categoría profesional; tipo de entrega; calificación y entrenamiento de los equipos.

Conclusiones: La superación profesional combinada con el estímulo del liderazgo, la colaboración entre pares, las buenas condiciones de trabajo, los recursos humanos y la infraestructura y la orientación a las familias brindan adherencia a las prácticas de cuidado humanizado del recién nacido en la sala de partos.

Palabras clave: Recién nacido. Parto humanizado. Atención perinatal. Salas de parto.

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INTRODUCTION

Care for healthy full-term newborns (NB) in the delivery room has undergone several changes and, currently, one of the main objectives is to reduce the excess of interventions applied to them soon after birth[1]. Humanized care during childbirth refers, therefore, to the need for a new look at this event, understanding it as a truly human experience[2]. Thus, the Prenatal and Birth Humanization Program aims to promote improvements in access, coverage and quality of prenatal care, but also in childbirth and postpartum care for the mother-child binomial[3].

The World Health Organization (WHO) recommends different care during childbirth for a positive birth experience. Thus, invasive procedures such as nasal and oral suction are not indicated in babies that are breathing. Skin-to-skin contact with the mother during the first hour after birth is also recommended for all clinically stable NB, in order to promote breastfeeding and prevent hypothermia[4].

The Brazilian Society of Pediatrics (*Sociedade Brasileira de Pediatria* – SBP) also recommends conducts that benefit the newborn's adaptation to extrauterine life: maintaining body temperature between 36.5-37.5ºC, ensuring room temperature in the delivery room between 23-26ºC, drying the body and head segment with heated compresses and initiate skin-to-skin contact with the NB covered with a dry and heated cotton cloth. The baby can be positioned on the mother's abdomen or chest, avoiding loss of body temperature, while waiting for the timely clamping of the umbilical cord, which prevents iron deficiency anemia in the first months of life[5].

Following these guidelines, it is recommended to assess the NB's vitality, soon after birth, according to three questions: Full term pregnancy? Breathing or crying? Good muscle tone? Obtaining positive answers to all questions, regardless of the aspect of the amniotic fluid, the baby has good vitality, does not require resuscitation maneuvers and must remain with his/her mother after the umbilical cord is clamped, thus ensuring breastfeeding in the first hour of life[5].

However, invasive care practices for NB with good vitality in the delivery room, such as the use of inhaled oxygen and incubator and oronasopharyngeal, gastric and tracheal aspirations, are still recurrent and high in Brazil. On the other hand, early skin-to-skin contact and breastfeeding in the delivery room remain below desirable levels[1,6]. In this respect, the delivery and birth care model in Brazil is still technocratic, centered on professionals and based on inappropriate and unnecessary interventions[1].

Current studies in the context of birth have mainly focused on the care of premature and/or low birth weight NB and neonatal resuscitation practices or are linked to women's health[7,8]. Little or superficially, they address the humanized practices to be developed in the delivery room with the full-term baby with good vitality. Furthermore, studies claim low adherence to these practices and high frequency of application of invasive interventions[1,6].

Therefore, little is known about facilitating and hindering aspects, in this study called intervening factors, for the occurrence of good practices in hospital delivery, proven to be beneficial to the NB. In this sense, it is important to develop research that aims to identify possible intervening factors in the adherence of health professionals to humanized practices with NB in the delivery room so that care, educational and managerial strategies are adopted that favor adherence and, consequently, promote the comprehensive and humanized care for the baby and their family.

Thus, the following research question is presented: What are the factors that interfere in the adherence of health professionals to humanized care practices for NB with good vitality in the delivery room? In line with this argument, the objective was to know the intervening factors in the adherence of health professionals to humanized care practices for NB with good vitality in the delivery room.

METHOD

Descriptive and exploratory research, with a qualitative approach, developed in the state of Rio de Janeiro, Brazil, online, through the Google Forms Virtual Platform. It was adopted the Consolidated Criteria for Reporting Qualitative Studies (COREQ)[9].

Thirty-six health professionals participated, who met the inclusion criteria: being a nurse, physician, technician or nursing assistant who works in the care of the binomial in delivery rooms in the state of Rio de Janeiro. Professionals who perform exclusively administrative activities were excluded.

To capture the intended participants, selection by convenience was adopted, using the snowball technique, which consists of a form of non-probabilistic sampling, through reference chains to locate possible participants who met the eligibility criteria, regardless of the work institution. Thus, the professionals were initially invited by the research team (a nursing student, a nurse undertaking doctorate and four teaching and doctoral nurses with academic and professional experience in the subject), among their professional contacts.

Subsequently, based on the indication of the participants and also by messages through social media (Facebook, Instagram and WhatsApp), it was sought to close the composition of the sample through theoretical saturation[10], since the answers became repetitive and the addition of

new information was no longer necessary, as it no longer altered the understanding of the phenomenon studied, the collection was closed.

Data collection took place between March and April 2021, through an individual semi-structured online form consisted of open and closed questions. This instrument was built on the Google Forms Virtual Platform, by providing a link, favoring the access of participants, through computer, notebook, tablet or smartphone. The approach was remotely, by sharing the research link, in which an invitation text was presented containing detailed and clear information about the objectives of the study and the secrecy, anonymity and confidentiality of the data. It was also clarified that the average time to complete the form was 15 minutes.

When clicking on the link, the user was directed to the Google Forms platform with access to the first page of the form that contained two filter questions: 1) If the work institution was located in the state of Rio de Janeiro; 2) If the participant worked in the care for the binomial in the delivery room. If these two answers were not affirmative, a thank you and end-of-participation page was displayed. Otherwise, the participant was directed to the page with the Free and Informed Consent Form (FICF), thus, the participant could only continue after reading and accepting this form online. To complete the participation, the professional needed to fill in the form and send it at the end, with the possibility of requesting sending a copy of the answers to the personal email. There were no dropouts regarding participating the research.

The form, built by two authors and validated regarding appearance and content by other members of the research team, had closed questions to characterize the participants: gender, age, municipality of residence, municipality of work, education, training, professional category, working time, type and number of institutions of activity and professional training. Another part contained open questions about the object of study: "How do you participate in the care for NB with good vitality in the delivery room?", "Do you know the humanized care practices for NB with good vitality in the delivery room? What would these be?", "In the environment in which you work, what do you observe that has been developed?", "What are the facilities to implement them?" and "What are the difficulties to implement them?". The form was tested by application with four professionals, which would allow to identify possible weaknesses and necessary adaptations, however, there was no need for modifications, so these responses were included in the analysis.

Data analysis took place in three stages: 1) preparation and coding of the textual corpus; 2) processing of textual data in the software and 3) interpretation of the findings by the researchers. The discursive answers from the forms constituted the primary source of data, which was duly prepared and submitted to text processing in the software *Interface de R pour Analyses Multidimensionnelles de Textes Et de Questionnaires* (IRAMUTEQ). Analytical methods were used: Word Cloud, Similitude Analysis and Descending Hierarchical Classification (DHC). In the last one, the active forms (nouns, adjectives, verbs and unrecognized forms) that presented $\chi 2$ equal to or greater than 3.84 ($p<0.05$) were selected for determining the associative strength between them, with emphasis on those with $p < 0.0001$, which denotes a very strong association of the word in the class[11].

After processing in the software, the interpretation phase took place in the light of the theoretical assumptions of qualitative research[12], through valuation, understanding, data interpretation and their articulation with the conceptual frameworks of the study. Thus, in the analytical process, it was decided to use elements of Thematic Content Analysis[12], in order to identify and analyze, through inferences, the nuclei of meaning produced by the text segments in the classes generated by IRAMUTEQ. Therefore, after reading the words and text segments associated with each class, it was possible to name them, based on the meanings of the answers, which together allowed achieving the objective of the study.

Study approved by the Research Ethics Committee (CAAE: 43457821,00000,5243, Opinion:4,598,500). The FICF was made available online and to the participants were guaranteed the secrecy, anonymity and confidentiality of the information. An alphanumeric code was used with the letter P followed by a number in order of participation in the research.

RESULTS

A total of 36 professionals (100.0%) participated, of which 35 (97.2%) were women, 16 (44.4%) aged between 31 and 40 years, living in the state of Rio de Janeiro (100%), 19 (52.8%) living in the capital, while the others live in other regions of the state: Metropolitana, eight (22.2%), Baixada Fluminense, three (8.3%), Baixada Litorânea, three (8.3%), and Serrana, three (8.3%). Nurses predominated, 29 (80.6%), followed by nursing technicians, four (11.1%), physicians, two (5.6%), and one (2.8%) nursing assistant. Seventeen (47.2%) have been in the profession for more than 10 years, 13 (36.1%) have a specialization, nine (25.0%) have undergraduate degrees, 11 (30.6%) have a master's degree, two (5.6%) doctorate and one (2.8%) post-doctorate.

Regarding the work in the area of health care for the NB, 11 (30.6%) work between one and five years, seven (19.4%) from 11 to 15 years, six (16.7%) from 6 to 10 years, five (13.9%) from 16 to 20 years, five (13.9%) over 20 years and two (5.6%)

less than one year. A total of 33 (91.7%) professionals work in the public network. Regarding the time working in the delivery room, those with more than 10 years prevailed, 12 (33.3%), followed by those from 1 to 3 years, eight (22.2%), and from 6 to 9 years, seven (19.4%), then, those with less than one year, six (16.7%), and those between 3 and 6 years, three (8.3%). Regarding training programs in the area, 25 (69.4%) participated.

The textual corpus, after processing by IRAMUTEQ, consisted of 36 texts, with 2,289 occurrences of words, with 543 distinct words and 289 with a single occurrence (hapax). Through the Word Cloud, without using a cut-off point for the inclusion of terms, it was possible to visualize the most representative words, these being the largest and in a more centralized way than the others (Figure 1).

In order of ranking, the ten most frequent active forms were: skin-to-skin contact (f=48), team (f=34), newborn (f=33), breastfeeding (f=27), cord (f=27), mother (f=26), no (f=25), first hour (f=25), care (f=23) and timely clamping (f=22). It was found that among the most recurrent active forms, the three main humanized practices to be performed in the delivery room appeared: skin-to-skin contact, timely clamping and breastfeeding. Therefore, it was found, initially, that the participants recognize such practices in the context of the immediate care to be developed with the NB.

> *Skin-to-skin contact soon after birth, timely clamping of the umbilical cord, early breastfeeding, care taken without rush so as not to interrupt the first contact between mother and baby.* (P2)

> *Yes, skin-to-skin contact immediately after birth for as long as is comfortable for the binomial (ideally at least one hour), timely clamping, timely breastfeeding as early as possible.* (P27)

In the Similitude Analysis, active forms with recurrence of six or more times were included, enabling to identify the words and the connections (links) between them. Thus, the

Figure 1 – Word cloud. Rio das Ostras, Rio de Janeiro, Brazil, 2021
Source: IRAMUTEQ. Research data, 2021

terms referring to humanized care for the NB appear highlighted from the center to the ramifications. Furthermore, skin-to-skin contact assumed a position of centrality and visibility, with a greater number of connections with the other terms (Figure 2).

There were ramifications of the main terms for other words that are connected, being the strongest and most recurrent those represented by thicker lines. Therefore, the robust connectivity of the active form "skin-to-skin contact" with the terms "breastfeeding", "breastfeeding mother", "first hour", "timely clamping" and "newborn", among others, demonstrated its importance and interconnection so that the different humanized practices with the baby take place in the delivery room. In this sense, the "skin-to-skin contact" proved to be a central element, acting as a guiding thread for the other care to be performed. This practice was considered doubly important, both as a humanized practice and as a factor that predisposes the occurrence of other.

I make skin-to-skin contact right after birth, dry and warm the baby, I take the opportunity to assess him while still on the mother's lap, encourage early breastfeeding and timely clamping of the umbilical cord. (P1)

If possible, we perform the first skin-to-skin contact, in addition to start early breastfeeding within the first half hour. (P35)

If born with good vitality, drying and heating in skin-to-skin contact with the mother and early start of exclusive breastfeeding on demand. (P17)

As the Similitude Analysis highlights, the term "skin-to-skin contact" also has a strong link with the word "team", which refers to its importance, as they are the professionals who intervene so that humanized practices with the NB occur or not in the delivery room. Also, it was observed that in the multidisciplinary team, nurses stand out, being those who most adhere to good practices, on the other hand, physicians (obstetricians and pediatricians) are cited as those who least comply with them, according to the participants.

I believe that because it is a hospital that receives many residents in obstetric nursing, the nursing team tries to

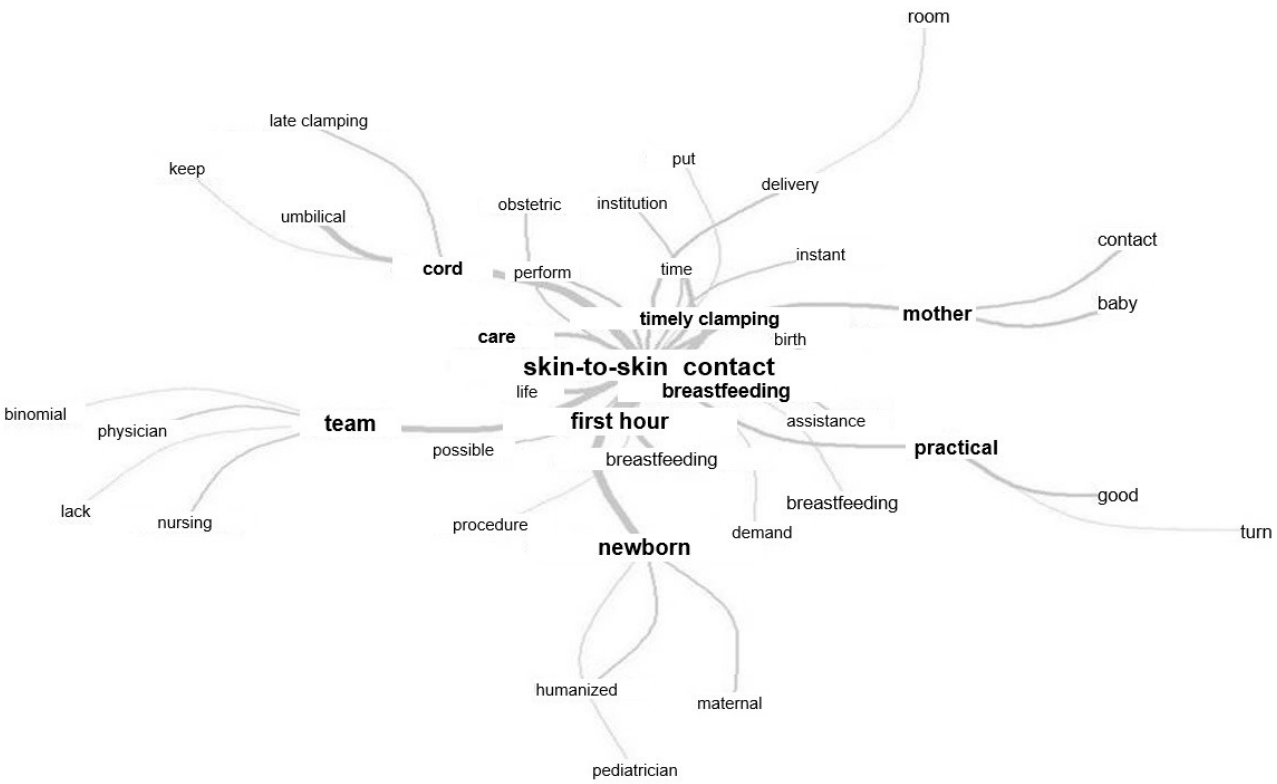

Figure 2 – Similitude analysis. Rio das Ostras, Rio de Janeiro, Brazil, 2021
Source: IRAMUTEQ. Research data, 2021.

reproduce much more respectful practices with birth and care for the binomial. Sometimes, some professionals (mainly pediatricians) tend to provide more traditional and old-fashioned care. (P1)

Humanized practices, however, by obstetric nurses. (P20)

The team of obstetric physicians performs immediate clamping. (P23)

In addition, the organization of the institution was highlighted by the participants as something that is directly related to adherence to good practices, which includes the importance of establishing institutional protocols and updates.

Organization, institutional protocol, commitment of coordination with the team. (P21)

Institution updated with good practices and understanding of the importance of the process. (P34)

Coordination works to update the team and integrate care within the recommended by the Ministry of Health. (P20).

In the Descending Hierarchical Classification, the dendrogram was generated with five stable classes, using 84.06% of retention of the 69 text segments (Figure 3). Classes were formed by words that are significantly associated with that class (by calculating χ2).

The class with the highest number of text segments was class 5 (pink), corresponding to 24.1%; followed by classes 3 (green) and 4 (blue) with 22.4% both, finally, classes 1 (red) and 2 (yellow) with 15.5%. The textual corpus was divided into two independent blocks (subcorpus), the first consisted of class 2, which shows that this is the most isolated, with distancing from its semantic content in relation to the others, as it is the only one that refers to institutional factors.

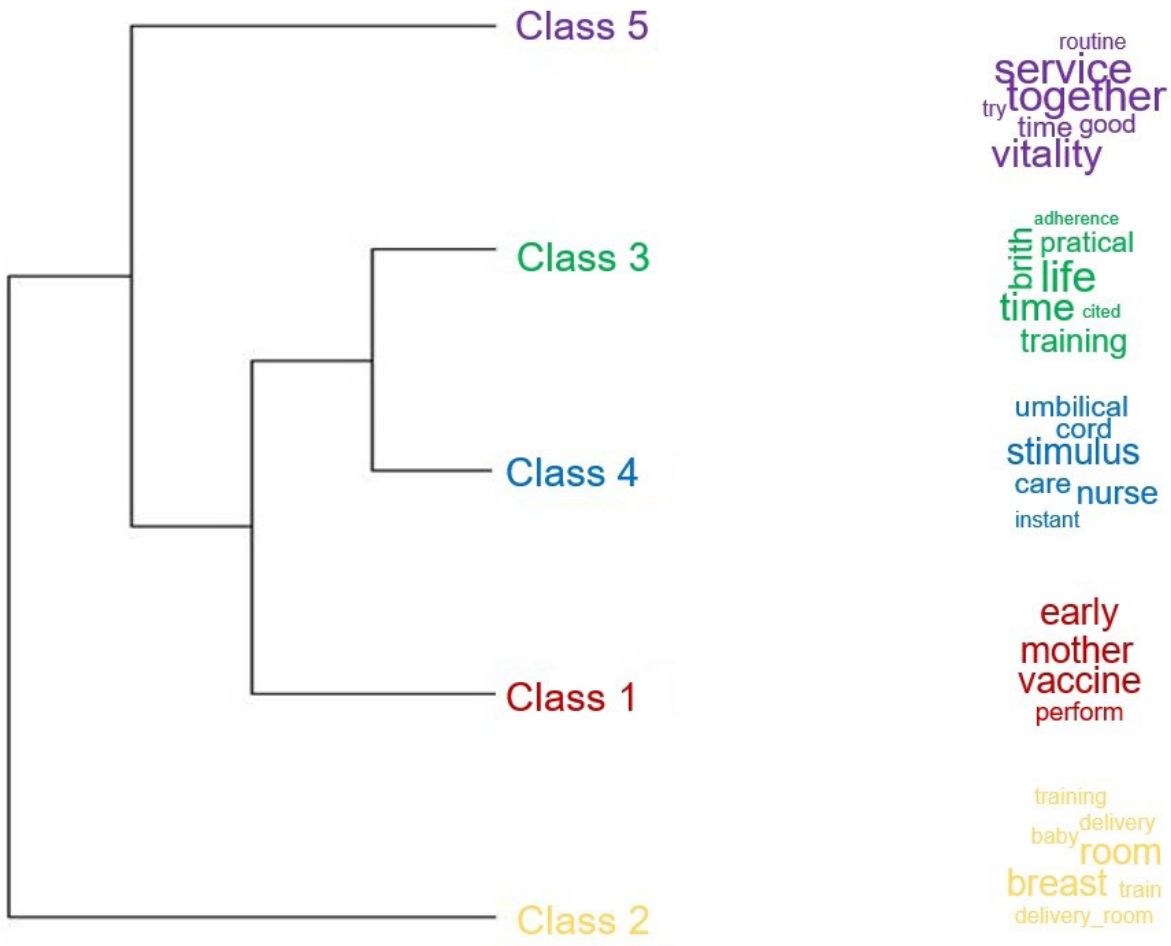

Figure 3 – Descending Hierarchical Classification. Rio das Ostras, RJ, Brazil, 2021
Source: IRAMUTEQ. Research data, 2021.

The second originated class 5, with a second subdivision for class 1 and a new subdivision encompassing classes 3 and 4, demonstrating greater proximity and homogeneity between them, which present closer semantic contents on training and training of the health team.

Class 1 – Acceptance of health professionals to adhere to humanized practices in the delivery room

This class encompasses words that refer to the importance of accepting and performing humanized practices in the delivery room, in order to promote the strengthening of the mother-baby bond. Professionals recognize that the ideal is to perform skin-to-skin early contact and that all other procedures are performed on the mother's lap or postponed, such as anthropometric measurements, vaccination and prevention of ophthalmia neonatorum.

> *We perform the first skin-to-skin contact, in addition to the early initiation of breastfeeding within the first half hour. Humanization of childbirth and strengthening the mother-baby bond.* (P35)
>
> *The baby is born, dries, places it on the mother's breast, starts breastfeeding immediately. Make skin-to-skin contact, show the mother signs of hunger, start breastfeeding immediately after delivery, postpone care such as measurement, vaccine, crede.* (P10)
>
> *Get the vaccines with the newborn at the breast. (*P26)

In the set of humanized practices, the presence of the companion chosen by the mother, who may even be chosen to cut the umbilical cord, also emerged as an important element.

> *Breastfeeding in a humanized way, thinking about the mother-baby well-being, presence of the companion chosen by the mother.* (P10)
>
> *Keeping the newborn warm, on the mother's lap. Let the newborn with the mother at all times. Cut the cord only after it stops pulsing. Let the mother choose who cuts.* (P13)

Given the recognition of humanized practices and its importance, the participants claimed that acceptance by professionals is a basic condition for them to be effectively performed. Therefore, when there is concern and respect from the team, these practices take place, which was recurrently associated with nursing. Therefore, the non-acceptance of these practices was described as a limiting factor for their occurrence.

> *Good acceptance of all those involved in the act of birth (ease).* (P31)
>
> *In the institution where I work, it is possible to see the concern of the team in keeping the moment of birth respectful. We always try to maintain the bond and respect for/with the binomial. I notice that the most respectful practices come more from the nursing team.* (P1)

Class 2 – Institutional intervening factors in adherence to humanized practices in the delivery room

Class 2 encompasses words that indicate institutional factors that interfere with adherence to good practices in the delivery room, namely: type of delivery, high demand for care, shortage of delivery rooms, working conditions, lack of information and lack of motivation of professionals and training of the teams. According to the participants, cesarean deliveries favor the non-occurrence of good practices in the delivery room, while in vaginal delivery (normal) humanized care takes place more frequently.

> *When it's vaginal delivery, breastfeeding. When there is cesarean section, there is no breastfeeding in the operating room.* (P8)
>
> *In normal deliveries we practice all humanized care. In cesarean sections we still have little skin-to-skin contact.* (P4)

Other institutional issues were highlighted, such as the high demand for deliveries and the lack of delivery rooms, which emerged as factors that limit the occurrence of humanized practices. And, in addition to the unfavorable working conditions, the lack of information and lack of motivation of some professionals were also identified as hindering factors.

> *Most (humanized practices) do not happen like that, because there are many women giving birth and few delivery rooms. There should be more delivery room.* (P13)
>
> *Work overload, need to rotate beds (difficulty).* (P27)
>
> *Routines addicted to misinformation and little motivation. Easier not to practice.* (P4)

To ease adherence, several professionals indicated that the constant training of the multidisciplinary team promotes humanization in the delivery room. Therefore,

continuing education is an intervening factor related to institutional conduct.

> *Appropriate team training. Trained team facilitates implementation.* (P9)
>
> *Team training and awareness. Training and updating courses.* (P27)
>
> *Training with the multidisciplinary team, as well as continuing education.* (P24)

Class 3 and 4 – Training and education of the health team related to adherence to humanized practices in the delivery room

In class 3, different associated words were evidenced, with emphasis on the term "training" that emerged as an important element. The semantic content of this class revealed a duality, because on the one hand, the training of the team is an essential factor for adherence to humanized practices in the delivery room, on the other hand, the lack of training emerges as a hindering element.

> *Training courses (ease).* (P12)
>
> *Resistance and lack of training of the medical team (obstetricians and pediatrics). Lack of training of the medical team (difficulty).* (P21)

In this directive, the adherence of professionals to good practices in the delivery room is variable. Some adhere to these behaviors, which is recognized as a facilitating factor, however, others do not put them into practice in the care for the NB, which is demonstrated by the recurrence of the word "lack" in the textual corpus.

> *Adherence of most of the team (ease). Lack of adherence by some members of the multidisciplinary team (difficulty).* (P36)
>
> *Trained team with good adherence (ease). Team without adherence (difficulty).* (P16)
>
> *Lack of sensitization of the medical team. (difficulty).* (P12)

The nursing team was repeatedly cited as the one that most promotes humanized practices with the baby. Still, one of the participants reported that the will of each professional and the partnership between the team in the institution is an element that interferes in this process, even varying from shift to shift in the same unit. In addition, the fact that the institution adhered to the Baby-Friendly Hospital Initiative (BFHI) also emerged as a factor that facilitated adherence.

> *The practices of humanization of delivery are being put into practice especially by the nursing team.* (P35)
>
> *These are implementations that do not depend on cost for the institution, only the will of professionals from different categories. Partnership and professional will.* [...] *In some shifts (humanized) practices are performed.* (P37)
>
> *The hospital has become baby-friendly recently.* (P3)

In class 4, it is observed that the type of training of health professionals is a factor related to adherence to good practices in the delivery room. Therefore, training based on the model of humanized health care promotes recommended practices. However, training based on the biomedical model emerged as a factor that hinders implementation.

> *Obstetric nurses trained in a model of humanization to care for newborns (ease).* (P19)
>
> *Skin-to-skin contact and breastfeeding in the first hour of life, late clamping of the umbilical cord, when the binomial is assisted by obstetric nursing.* (P23)
>
> *Rigid training models in interventionist protocols (difficulty).* (P06)
>
> *Professionals who were not trained for the practice of humanized reception of newborns with good vitality.* (P18)

Another factor highlighted as a limiting factor for the implementation of good practices is the overload of activities in the unit, with a high number of visits, added to the reduced number of professionals to meet this demand, demonstrating that only the training and education of the team regarding humanized practices are not enough if the professional is faced with limiting institutional factors.

> *Unit overcrowding (difficulty).* (P19)
>
> *A professional overloaded with the sector's demand cannot implement (difficulty).* (P27)
>
> *High demand for care, insufficient number of professionals for the demand (difficulty). (*P18)

Class 5 – The pediatric medical team and its relationship in the adherence to humanized practices in the delivery room

In this class, the word "pediatrician" was recurrent and presented a strong association. The interpretation of the text segments made it possible to verify, in several responses, that the performance of this professional, including the medical coordination, sometimes distances itself from good practices,

mainly due to the search for optimizing the assistance time. Therefore, it is recognized as a factor that hinders the adherence to humanized practices.

> *Sometimes, some professionals (mainly pediatricians) tend to provide more traditional and old-fashioned care.* (P01)
>
> *Medical coordination and older pediatricians (difficulty).* (P29)
>
> *Still the time of the pediatrician, who wants to optimize and/or accelerate their time in newborn care (difficulty). Not all, but some of them.* (P25)

The medical class at various times was referred to as the one that least adheres to humanized practices in the delivery room. Moreover, the outdated and misinformation on the subject imply the adoption of old routines. However, the dissemination of scientific evidence eases the implementation, as well as the valuation of these practices by the leadership.

> *The preceptors do not always let me perform these steps, hindering the golden hour to perform care for the newborn. As well as pediatrics and obstetricians who do not always comply with this conduct.* (P7)
>
> *Outdated professionals, especially from the medical team and the old routines of the sector (difficulty). The increasingly disseminated scientific evidence facilitates the implementation of good practices in the service.* (P35)
>
> *There must be a leadership that values good practices and works to train the entire team.* (P4)

DISCUSSION

The intervening factors in the adherence of health professionals to humanized care practices for NB with good vitality in the delivery room are multidimensional and involve individual and institutional issues. The findings revealed that professionals recognize the main humanized practices, which the literature points out to be of extremely important for adherence to them to occur[13], as it is the starting point for their implementation.

Most participants have experience in the area and professional qualification, which corroborates a study that highlighted the importance of continuing education to improve the quality of care and encourage good practices in obstetric scenarios[14]. Therefore, in professional training, it is essential to change the paradigm regarding the current hospital-centric culture of childbirth care[13], as the findings also indicated, reinforcing the need for training based on the humanization of delivery.

As for the humanized care performed with the NB in the delivery room, skin-to-skin contact assumed a central position in the analyses, being recognized as a practice and a factor closely related to the performance of the others. National and international recommendations agree with these findings, emphasizing its importance, since this practice helps in the thermal regulation of the NB, preventing hypothermia, stimulating the bond between the mother and child binomial, in addition to promoting and establishing breastfeeding[4–5,13,15].

A systematic review of 38 clinical trials with 3,472 binomials from 21 countries, found that babies placed in skin-to-skin contact soon after delivery are breastfed more frequently for 1-4 months after delivery and the first feeding is more likely to occur with success[16], reinforcing that this practice is a guiding thread for the others.

Some professionals claimed that they first perform humanized care, postponing other procedures, including invasive ones, such as vaccination. This attitude corroborates the scientific evidence, as it favors the adaptation of the NB to extrauterine life. Routine exams and procedures should only be performed after early skin-to-skin contact, except when medically indicated[4,14]. However, studies show that there is still resistance by professionals to postpone tasks and routine care in favor of good practices[13]. A research carried out in the coast of Rio de Janeiro showed that in addition to low adherence to good practices, the rates of invasive interventions in the delivery room, especially oronasopharyngeal and gastric aspirations, were high[1], which is in line with the responses of the participants and is opposed to the current guidelines[4].

In view of the findings, the institutional organization is configured as another intervening factor in adherence to humanized practices, in addition to the professional training model. Evidence confirms this directive, highlighting that the performance of the multiprofessional team is still biological and interventionist, emphasizing that the hospital routine overlaps humanized care[13,17]. These findings refer to the importance of academic training and humanized institutional protocols, as the health team needs to concretely support good practices to benefit mothers and babies[14].

The acceptance of health professionals is also a basic condition for good practices to be performed. Thus, according to the results, when there is interest, concern and respect on the part of the team, these practices happen, as another study also revealed[14]. In this aspect, the nursing team stood out as the one that most adheres to good practices, especially skin-to-skin contact, which is also consistent with

the literature[13,18]. On the other hand, the non-acceptance of these practices by some members of the health team is a limiting factor for their occurrence.

The medical category was highlighted as a group of professionals that many times do not adhere to good practices, which is in line with the literature that points out that pediatricians are those who choose to maintain invasive practices, sometimes unnecessary, at the time of delivery, including distancing the NB from the mother, which is a barrier to early skin-to-skin contact[13], and indiscriminate aspiration of the airways, both measures are opposed to the recommendations of the WHO and SBP[4,5]. Therefore, it is recommended that physicians also participate in institutional training on good practices at childbirth[13].

Work overload, as well as the high demand for deliveries and the insufficient number of professionals, also reported in other studies[13,17], configure as intervening factors in the adherence to humanized practices in the delivery room. A study in Paraná/Brazil highlighted that the low adherence of other professionals, especially physicians, also generates work overload on those involved in the adoption of early skin-to-skin contact and breastfeeding in the delivery room[17], which enhances the difficulties for the implementation of the fourth step of the BFHI and consistent with the current results.

The presence of the companion chosen by the mother, who may even be selected to cut the umbilical cord, was also highlighted in the study. This presence tends to favor the humanization of obstetric and neonatal care, reducing unnecessary interventions and contributing to humanized practices[13,14].

Vaginal delivery emerged as a facilitator and cesarean delivery as a hinder to adherence to good practices. Studies confirm that cesarean section favors the postponement of mother-baby contact, not only due to the biological effects resulting from the surgery, such as drowsiness of the mother due to analgesia, but also by professionals who postpone this practice due to postoperative care[13,14,19]. On the other hand, vaginal delivery is a protective factor for humanized practices, increasing the chances of the baby being in contact with the mother after birth[6,19]. However, good practices should be performed in all types of delivery[14].

Professionals reported working in institutions called "Baby-Friendly Hospital", which, in order to maintain the title, need to follow specific rules related to humanized care and breastfeeding[6]. On the other hand, a study claims that despite the existence of the Stork Network and BFHI, the occurrence of these practices in Brazil is still low[14].

It is not different in other countries, for example, a French study with 85 mothers found that in 67% of deliveries the duration of skin-to-skin contact was less than one hour and in 49% the main reason was to perform routine care. This separation goes against current recommendations, interrupts the skin-to-skin contact of the NB with their mother, impairs the success of breastfeeding and potentially hinders the establishment of the first mother-child bonds[20]. This reinforces the importance of current findings and the need for care, educational and managerial actions that promote such practices in different scenarios.

Thus, the care model in which cesarean delivery and invasive interventions prevail still predominates in delivery rooms[1]. However, it is essential to sensitize managers and professionals who work directly in assistance for the creation or strengthening of institutional policies that promote good practices. In addition, it is necessary for the multiprofessional health team to be updated on the scientific evidence to ensure a positive birth experience, avoiding unnecessary interventions[4,13,15].

Therefore, actions aimed at raising the level of knowledge of professionals about the importance and benefits of good practices are recommended; guidance to families before the childbirth about the care for the healthy NB in the delivery room; and establishment of a care protocol for the NB with good vitality, including skin-to-skin contact, remembering that routine care can be postponed[20].

Considering that the research was developed in the state of Rio de Janeiro, the importance of studies in other demographic regions is recognized, in order to observe regional convergences and divergences in adherence to good practices for newborns at birth. Most of the participants are nurses, which was another limitation of the study, so it is suggested to expand to the medical category, despite invitations having been made. Another limitation refers to the use of an online form, which resulted in shorter and more objective responses among the participants compared to face-to-face interview, thus indicating the importance of studies with other methodological designs to expand knowledge about the theme.

The study contributes to the health area by presenting intervening factors in the adherence to humanized practices with NB with good vitality in the delivery room, thus allowing the elaboration and adoption of care, managerial and educational strategies, both at a technical and undergraduate level and at post-graduate level, which favor the occurrence of these practices.

CONCLUSIONS

In this study, multidimensional factors were identified that interfere with adherence to humanized care practices for NB with good vitality in the delivery room, among them, skin-to-skin contact stood out as a facilitator for the occurrence of timely clamping of the umbilical cord and breastfeeding in the first hour of life.

The acceptance of the team, type of training and professional category were also mentioned, since the participants signaled the importance of acceptance by the professionals themselves regarding the implementation of good practices, with the nursing team being recurrently associated with their occurrence. Different institutional intervening factors were also revealed, namely, type of delivery, high demand for care, lack of delivery rooms, inadequate working conditions, lack of information and lack of motivation among professionals. Therefore, the need for qualification and training of the teams was recurrent in the responses of the participants.

Considering that an important critical node is still the need for acceptance by the team to adherence to humanized practices, institutional policies that promote good practices in the delivery room are essential. Therefore, professional improvement with updated knowledge, combined with encouragement from the leadership, partnership between peers, good working conditions, human resources and infrastructure and guidance to families are some strategies that provide this adherence.

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